SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator Roy Ashburn

May 14, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

AGENDA #1
(Diane Van Maren)

Item	Department
4270	**California Medical Assistance Commission (CMAC)—Vote Only**
4440	**Department of Mental Health—Vote Only**
4265	**Department of Public Health**
4260	**Department of Health Care Services**

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Public comment is welcomed.

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A. Items for "Vote Only"--Pages 2 through 5

1. CA Medical Assistance Commission: Technical Adjustment

Background and Budget Discussion Issue. The CMAC negotiates contracts with certain hospitals under the Medi-Cal Program (called the Selective Provider Contracting Program), as well as contracts for Geographic Managed Care within the Medi-Cal Program (for Sacramento and San Diego).

The Subcommittee is in receipt of a Spring Finance Letter from the CMAC requesting an increase of $29,000 (Reimbursements which are federal funds from the Department of Health Care Services) for contract negotiation activities.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. This is a technical adjustment and no issues have been raised. It is recommended to approve the Finance Letter.

2. DHCS: Technical Adjustment for the Expanded Access to Primary Care

Background and Budget Discussion Issue. The Expanded Access to Primary Care Program reimburses community clinic providers for primary care services delivered to patients with family incomes at, or below, 200 percent of poverty who have no other means to pay. The state reimburses at $71.50 per visit.

During the current-year, the EAPC Program will reimburse 197 non-profit community clinic corporations for services at 548 clinic sites in 52 counties and pay for about 378,000 visits that would have otherwise been uncompensated.

The Subcommittee is in receipt of a Spring Finance Letter from the Department of Health Care Services (DHCS) that requests a transfer of $200,000 (Cigarette and Tobacco Product Surtax Funds—Proposition 99 Funds) from DHCS state operations to local assistance within the EAPC to help pay for administrative costs associated with the processing of claims generated by community clinics participating in the EAPC.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. The transfer of funds from state operations to local assistance to help with claims processing makes sense. This is a technical adjustment and no issues have been raised. It is recommended to approve the Finance Letter.

3. DHCS: Delay Implementation of CA Discount Prescription Drug Program

Budget Discussion Issue. The Subcommittee is in receipt of a Spring Finance Letter from the Department of Health Care Services (DHCS) requesting to delay implementation of this new program for one more year due to the fiscal crisis.

Overall Background—AB 2911 (Nunez), Statutes of 2006. This legislation created the CA Drug Discount Prescription Drug Program to address concerns regarding the lack of access to affordable prescription drugs by lower-income Californians. This program is a drug discount program, not a benefit. The general structure of the program is for the state to negotiate with drug manufacturers and pharmacies for rebates and discounts to reduce prescription drug prices for uninsured and underinsured lower-income individuals.

Participation in the program is eligible uninsured California residents with incomes below 300 percent of the federal poverty, individuals at or below the median family income with unreimbursed medical expenses equal to or greater than 10 percent of the family's income, share-of-cost Medi-Cal enrollees, and Medicare Part D enrollees that do not have Medicare coverage for a particular drug.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. Though implementation of this new program has merit, due to the fiscal crisis it is recommended to adopt the Spring Finance Letter to delay implementation of this program for 2009-10. The state is not in a position to commence with a new program when existing core programs are being reduced.

4. DPH: Trailer Bill Language for Emergency Physicians & Proposition 99 Funds (See Hand Out Package)

Budget Discussion Issue. The February budget package appropriates $24.803 million (Proposition 99 Funds) to reimburse physicians, surgeons and hospitals for uncompensated emergency medical services within the Department of Public Health (DPH). This appropriation is consistent with appropriations made for this purpose for the past several years, since 2000. These funds are used at the county level to reimburse physicians for uncompensated emergency medical services to persons who cannot afford to pay for such services.

Trailer bill language to allocate these funds to emergency physicians is also needed. The trailer bill language provided by the DPH for this purpose is the same language that was adopted for last year's process.

Subcommittee Staff Comment and Recommendation—Adopt Trailer Bill Language. No issues have been raised regarding this language. It is recommended to adopt the language as proposed.

5. DMH: Trailer Bill Language for Patton State Hospital

Budget Discussion Issue. The DMH is proposing trailer bill language to extend by three years, from September 2009 to September 2012, their ability to house up to 1,530 penal-code patients at Patton State Hospital. The DMH is requesting this change due to the continued growth of penal code patients which exceeds the State Hospital systems legally defined capacity and the need to house penal code patients in a "secure facility".

The DMH notes that presently Patton State Hospital is licensed to house 1,287 patients and currently houses about 1,506 patients. The Department of Public Health has been providing licensing waivers for the DMH to "over-bed" for several years at Patton.

Due to pressures to make more beds available to accommodate ISTs, respond to the number of orders to show cause, changes to the SVP law, and the recent joint Coleman/Valdivia court order to take in parolees, the DMH expects continued growth in its forensic patient population.

Prior Subcommittee Hearing. This issue was discussed in the March 26th hearing. Since this facility has the ability to best accommodate this population, no issues were raised.

Subcommittee Staff Comment and Recommendation—Adopt Trailer Bill Language. No issues have been raised regarding this language. It is recommended to adopt the language as proposed.

6. DMH: Technical Adjustment for Program Reimbursements

Budget Discussion Issue. The Subcommittee is in receipt of a Finance Letter from the DMH that requests an increase of $40 million in Reimbursements (from County Mental Health Services Act Funds) and a decrease of $40 million from the Mental Health Services Act Funds due to a technical error by the Administration. This technical adjustment is requested to accurately reflect Reimbursements received from county Mental Health Services Act Funds, not state Mental Health Services Act Funds.

This technical fund shift is needed to make a correction regarding special projects of a state-wide significance. These projects include: (1) Suicide Prevention; (2) Student Mental Health Initiative; and (3) Stigma and Discrimination Reduction.

Subcommittee Staff Comment and Recommendation—Adopt Finance Letter. No issues have been raised with this Finance Letter. It is recommended to adopt it.

7. DMH: California Health Information Survey (CHIS)

Budget Discussion Issue. The Subcommittee is in receipt of a Spring Finance Letter that requests a *one-time* appropriation of $1.3 million (Mental Health Services Act Funds) to fund a mental health component of the California Health Interview (CHIS) Survey for 2009. It should be noted that a portion of Mental Health Services Act Funds have been used previously for this purpose.

This survey has been conducted every two years since 2001 and is the largest health survey of states in the nation. CHIS data are used by state agencies, local public health agencies, community-based organizations, health care providers, advocacy organizations, federal agencies, foundations, the Legislature, and researchers.

The DMH states that CHIS provides the opportunity to:

- Identify populations by socioeconomic, race/ethnic, or geographic characteristics that are underserved;
- Help specify the barriers that contribute to disparities in treatment utilization, including stigma, cost, and adverse experiences with treatment;
- Inform the California mental health policy debate with population data on mental health status and its links to physical health status, health insurance, and economic well-being.
- Highlights trends over time in mental health status and use of mental health services.

The total request for the mental health component of CHIS in 2009 is $1.568 million. The Finance Letter is requesting an increase of only $1.3 million since carry-over funds are also available for this purpose. The $1.568 million would be expended as follows:

- CHIS Adult survey content (ages 18 and up) = $1.333 million total
    - Mental Health Assessment = $751,000
    - Perceived need and utilization of mental health services = $261,000
    - Mental/emotional health disability and severity = $150,000
    - Stigma as a barrier to service utilization = $16,000
    - Suicide = $155,000
- CHIS Adolescent survey content (ages 12 to 17) = $92,000
    - Mental Health Assessment = $49,000
    - Perceived need and utilization of mental health services = $27,000
    - Suicide = $16,000
- Data Dissemination = $143,000

This is for developing and producing mental health "SNAPSHOTS", two policy research reports, and two policy briefs. The collected data is to be made widely and easily accessible through a number of different outreach methods.

Subcommittee Staff Comment and Recommendation—Adopt Finance Letter. No issues have been raised with this Finance Letter. The CHIS is a well-known survey that provides reliable data which can be used for many diverse purposes. Use of Mental Health Services Act Funds (Proposition 63, Statues of 2004) is appropriate for this purpose as well. It is recommended to adopt the Finance Letter.

B. Issues for Discussion—By Department

Emergency Medical Services Authority

1. Pharmaceutical Cache (Stand By) for Mobile Hospital

Budget Discussion Issue. Through the Governor's January budget, the EMSA requested an increase of $448,000 (General Fund) to fund a pharmaceutical cache for the Mobile Field Hospitals. This request *was not included* in the February budget package but it was agreed that it would be discussed through the Subcommittee process "without prejudice".

The EMSA states that this funding would ensure a fresh supply of pharmaceuticals to be on-hand and delivered within 48 hours of the deployment of a Mobile Field Hospital. Pharmaceutical caches consist of medications, treatment kits, intravenous solutions, and other medical supplies.

It should be noted that this same request was denied last year due to the fiscal crisis.

An allocation of $18 million (General Fund, one-time only) was provided in 2006 for the purchase of pharmaceutical drugs, maintenance, medical supplies and related materials. In addition, $1.7 million (General Fund, ongoing) was provided for pharmaceutical drugs, storage, staff and maintenance.

Subcommittee Staff Comment and Recommendation. In the event of an emergency, the Governor can authorize increased funding for medical supplies, including pharmaceuticals. Further, the state operates under a "mutual aid" agreement where by local governments also play a significant role in providing assistance, along with the federal government.

Due to the short shelf life of most pharmaceuticals (about 2/3rds have a 12-month shelf life with the remaining 1/3 having about an 18-month shelf like) the EMSA would need on-going support even if no emergency requiring pharmaceuticals occurred.

It is recommended to "hold" this issue "open" pending receipt of the Governor's May Revision.

Questions. The Subcommittee has requested the EMSA to respond to the following questions:

1. EMSA, Please provide a brief summary of the request.

Department of Public Health

1. New Health Associated Infection Surveillance, Prevention & Control Program

Budget Discussion Issue. The Subcommittee is in receipt of a Spring Finance Letter that requests an increase of $1.4 million (Licensing and Certification Fees) to support 11 new state positions to establish a Health Associated Infection Surveillance, Prevention and Control Program, as well as database development and website enhancement.

The purpose of this request is to respond to chaptered legislation—Senate Bill 1058 (Alquist), Statutes of 2008, Senate Bill 158 (Flores), Statutes of 2008, and Senate Bill 739 (Speier), Statutes of 2006—regarding healthcare associated infections. These three bills create the basis for this new program area within the DPH's Licensing and Certification Division.

The 11 positions requested to complete the requirements of the chaptered legislation, including public reporting processes, are as follows:

- Public Health Medical Officer III. This position would coordinate development and implementation of the Health Associated Infection (HAI) Program by **(1)** providing supervision and guidance to staff; **(2)** overseeing development of directives and guidelines for the reporting of HAI by hospitals; **(3)** conducting annual evaluations of the HAI surveillance, prevention and control activities; and **(4)** planning, organizing and coordinating the data reporting activities of the HAI, including the required data summaries of the hospitals.

- Two Nurse Consultant III's. These positions would be used to **(1)** provide oversight, consultation and education to the hospitals on the methodology for the collection of data to be reported to the DPH; **(2)** develop and publish directives and guidelines for the reporting of HAI; **(3)** conduct onsite evaluations of health facility data; **(4)** participate as a member, and assist in the coordination of, the HAI Advisory Committee; **(5)** review and evaluate federal and state regulations and accreditation standards; and **(6)** work with the health education consultant in the development of infection prevention information.

- Three Research Scientist/Analyst Positions. These positions would **(1)** develop and implement systems for the collection and reporting of HAI; **(2)** develop quality control protocols; **(3)** conduct statistical analyses and interpret results; **(4)** maintain database systems; **(5)** conduct stakeholder work groups to develop guidelines for reporting HAI data; and **(6)** provide field work assistance as needed to Licensing and Certification personnel regarding these issues.

- Health Education Consultant II. This position would **(1)** design, develop and host a public website for the display of mandated infection surveillance data and public education related to infection prevention and control; **(2)** perform timely posting of infection prevention data as it becomes available; **(3)** translate educational materials and interpretations of data to a language level suitable for the general public; **(4)** perform program evaluation including conducting an annual evaluation of the HAI data reporting program and making recommendations for program improvements.

- Health Program Specialist. This position would **(1)** develop, evaluate and research policy and regulations for HAI; **(2)** provide coordination for the activities of program in the prevention and control of community pathogens and HAI; **(3)** serve as a liaison between the program, local health departments, healthcare facilities and other agencies; and **(4)** assist in developing guidelines, educational programs materials and legislative reports.

- Two Support Positions. These positions would perform data entry, obtain data from hospitals as appropriate and provide clerical support for the program.

The DPH states that development of this program will fulfill the mandates of the chaptered legislation, including the updating of state guidelines for infection control and prevention which have *not* been updated since 1970. These state guidelines will also be made consistent with national guidelines and standards.

The DPH also states that "measurable goals and objectives will be established and updated" as needed. Process and outcome measures will be developed to evaluate the program's effectiveness and identify areas of weakness or needing improvement. Program evaluation is to be undertaken periodically to assess the program's effectiveness in meeting its goals, identify problem areas and specify activities to be undertaken for program improvement.

The costs associated with this workload would result in increased Licensing Fees to be paid by hospitals and nursing homes. According to the DPH, the impact on Licensing Fees for the proposal is as follows:

Table: Administration's Increase in Licensing Fees

Facility Type	2009-10 Base Fee (Per Bed)	Incremental Fee for HAI Proposal (Per Bed)	Total Revised Fees for 2009-10 (Per Bed)
General Acute Care Hospitals	$257.76	$18.58	$276.34
Acute Psychiatric Hospitals	257.76	0.21	257.97
Nursing Homes—Skilled	287.00	0.83	287.83

Background--Health Associated Infections (HAI). According to the DPH, healthcare facilities increasingly lack the capacity to adequately address infection prevention and surveillance problems, keeping up with changes in information and technology, or respond to outbreaks.

Health associated infections (HAI) that occur during or as a consequence of the provision of healthcare, are major public health problems in California. In California's 450 General Acute alone, account for an estimated 240,000 infections, 13,500 deaths, and $3.1 billion dollars in excess health care costs annually. Infections also occur in California's 1,500 nursing homes, 800 Intermediate Care Facilities, 600 ambulatory surgical centers, and 350 dialysis centers.

Subcommittee Staff Comment and Recommendation. The DPH's proposal appears to be consistent with the requirements contained within the legislation. No issues have been raised. It is recommended to approve the Spring Finance Letter.

Questions. The Subcommittee has requested the DPH to respond to the following questions:

1. **DPH,** Please provide a *brief* summary of the proposal and request for the positions.
2. **DPH**, What core components of the program will be implemented first as a priority?
3. **DPH**, The federal American Recovery Reinvestment Act (ARRA) provides $50 million in federal grants for states to address hospital acquired infections. Will California be applying for some of these federal grant funds?

2. Lead-Related Construction Program Funding

Background and Budget Discussion Issue. The Lead-Related Construction Program was created in 1993 to protect children, families and workers by preventing lead exposure from housing and public buildings in accordance with the federal Residential Lead-Based Paint Hazard Reduction Act of 1992 and Title X of the Housing and Community Development Act. Among other things, this program (1) provides accrediting training to instructors to teach students how to identify and correct lead hazards; and (2) certifies individuals who are qualified to identify and correct lead hazards. This DPH program is recognized by the U.S. Environmental Protection Agency (EPA) as an authorized state program which makes California eligible to receive certain federal grants.

The Subcommittee is in receipt of a Spring Finance Letter that requests an increase of $500,000 (General Fund) for the Lead-Related Construction Program. The DPH states that this request would restore half of the General Fund amount that was eliminated in the Budget Act of 2008 through a Governor's veto.

Specifically, about $1 million (General Fund) was vetoed by the Governor in 2008. However the Administration now recognizes that about $500,000 is annually deposited into the General Fund from fees collected through this program from certification fees.

Further, the Administration contends that the requested restoration of $500,000 (General Fund) is needed in order to maintain eligibility for federal grant funds received by the California Department of Community Services and Development. Specifically, the Department of Community Services and Development receives about $22 million (federal funds) annually from the federal Housing and Urban Development (HUD) for lead hazard control.

The DPH states that the federal government gave California permission to utilize certain federal grants for 2008-09 (about $747,000) to temporarily support the Lead-Related Construction Program, due to the Governor's veto. However, these funds end as of September 2009. It is not known at this time if additional federal funds can be obtained for continued operation of the Lead-Related Construction Program.

The DPH notes that 8,100 children were found to have elevated blood lead levels in 2007 and about 85 percent of the cases investigated indicate expose to lead-based paint and lead-contaminated soil. As such, the Lead-Related Construction Program is important to continue since it provides training for inspection for lead hazards and remediation.

Subcommittee Staff Comment and Recommendation. In lieu of the Finance Letter, it is recommended to **(1)** establish a special fund into which the fees for the program will be paid; and **(2)** appropriate $500,000 *(one-time only*) from the Occupational Lead Poisoning Prevention Account in lieu of using General Fund dollars for 2009-2010 to continue the Lead-Related Construction Program.

This action would not affect the General Fund, would better reflect the collection of fee revenues to be used for the program, and would continue the program for one more year so the state may obtain the federal grant funds.

The existing fee revenue deposited in the General Fund could remain for 2009-10. New fees collected during 2009-10 could be placed into a new special fund. This would clarify that these revenues are a "fee" and not a "tax".

The Occupational Lead Poisoning Prevention Account funds would be used on a one-time only basis for the program. The Fund Condition Statement shows there is a $1.7 million reserve in this fund. Therefore, $500,000 is available from this account and it is for a lead-related purpose.

Questions. The Subcommittee has requested the DPH to respond to the following questions:

1. DPH, Please provide a brief summary of the program and proposal.
2. DPH, Please comment on the staff recommendation from a "technical assistance" basis.

Department of Health Care Services

1. Medi-Cal Eligibility Verification—Trailer Bill, Contract Funds & Staff (See Hand Out)

Budget Discussion Issue. The February budget package provides $250,000 ($125,000 General Fund) for a contract, and funds for one Associate Governmental Program Analyst to conduct verification of assets for Medi-Cal applicants and enrollees whose Medi-Cal eligibility is based on being Aged, Blind, or Disabled (i.e., have these eligibility category aid codes). Trailer bill legislation is also proposed. The intent of this proposal is to comply with federal law changes.

The DHCS states this contract will be with a vendor to provide a secure, web-based means for counties to request asset information from financial institutions to supplement verification for Aged, Blind, or Disabled individuals in order to be compliant with new federal requirements. The vendor would also be required to track the required reporting elements based on the financial institutions responses and generate the reports for the DHCS when needed for submission to the federal CMS.

Prior Subcommittee Hearing—Concerns with Trailer Bill Language. In the April 23rd Subcommittee hearing, considerable concerns were expressed regarding the Administration's proposed trailer bill language. The Subcommittee discussed the language and requested the DHCS to work with stakeholders to re-craft it.

Key concerns expressed in this *prior* hearing included the following:

- The language requires an individual to consent to the asset verification process as a condition of Medi-Cal eligibility. This requirement is beyond that which is contained in the federal law.

- The language broadly states that asset verification authorization shall be provided "whenever the State determines that the record is needed." No criteria is established or even outlined regarding how and when the authorizations will be required or what standards will be used for these activities. Therefore, implementation by individual counties or eligibility workers will likely be inconsistent and even *possibly* unintentionally discriminatory.

- The language broadly states that assets shall also be provided "by any other person whose resources are required by law to be disclosed". This provision most likely violates legal agreements in *Sneed v Kiser* (728, Supp. 607 of 1990) which limits whose assets can be counted towards the Medi-Cal enrollee's eligibility.

- There are various important procedural issues which are not clear with the language or the proposal overall. Such as--Will these Aged, Blind and Disabled applicants be delayed enrollment for long periods of time due to the need for the asset verification process? Will all other written documentation be waived if electronic verification of assets is conducted? How are county eligibility workers to process and track this information?

Administration's Revised Trailer Bill Language (Hand Out). The DHCS has considerably modified its original trailer bill language. *Key* changes include the following:

- The revised language no longer requires asset verification to be a condition of eligibility. It adds subdivision (e) to Section 14013 to clarify that applicants or recipients of Medi-Cal that refuse to provide or choose to later revoke their authorization *may* be determined ineligible for Medi-Cal

- The revised language now requires the DHCS to work with counties and stakeholder groups. It adds (g) to Section 14013.5 to require the DHCS to work with counties and stakeholders to develop the criteria to be used for asset verification.

- In response to concerns with privacy protections the revised trailer bill language now includes a reference to federal law to add privacy protections and notifications to applicant/recipient under Section 14013.5(d).

- With regards to concerns with how information would be obtained from financial institutions, revised trailer bill language does the following:

    - Requires the DHCS to reimburse the financial institutions with no cost to the applicants and recipients;
    - Requires the financial institution to furnish the DHCS with bank records for applicants and recipients who have provided authorization;
    - Allows the authorization obtained by the DHCS to meet the requirements of the Right to Financial Privacy Act (Act)and allows the DHCS to waive the certification requirements of this Act with the obtain authorization from the applicant/recipient;

- The revised language makes other language changes to clarify the purpose of the statutory changes. These include the following key items:

    - Includes language that the asset verification system implementation would be pursuant to, and only to the extent required by, federal law.
    - Incorporates the basic provisions of the federal law into state law.
    - Includes language that the authorization to request asset information be required of only those applicants and recipients designated by the DHCS in conformance with federal requirements and guidelines.

Subcommittee Staff Comment and Recommendation. The DHCS has made a commendable effort to recraft their trailer bill language. It is recommended to adopt the revised trailer bill language as placeholder language with one modification. The DHCS needs to include a date or time period as to when the regulations would be developed. Subcommittee staff suggests for regulations to be in effect within three-years since it is a new process which is contingent upon federal guidance which is still pending.

Questions. The Subcommittee has requested the DHCS to respond to the following question:

1. **DHCS,** Please provide a *brief* description of the revised trailer bill language.

2. Trailer Bill Language to Establish Maximum Allowable Ingredient Costs for Generic Drugs Dispensed by Pharmacists (Hand Out)

Budget Discussion Issues. The February budget package includes savings of $2 million ($1 million General Fund) for 2009-10 by implementing trailer bill language to establish a *new* Maximum Allowable Ingredient Cost (MAIC) within the Medi-Cal Program. Annual savings are estimated to be $24 million ($12 million General Fund).

The savings assumes a June 1, 2010 implementation date by the DHCS since system changes and other administrative actions require time to implement. Trailer bill language needs to be enacted before this savings can be achieved. The DHCS will also be entering into contracts with a vendor and is seeking an exemption from certain Public Contract Code requirements in order to implement this system quickly.

The Administration's proposed trailer bill language would allow the Medi-Cal Program to set MAIC using *either* (1) the Average Manufacturer Price (AMP); (2) the Wholesaler Acquisition Cost (WAC); *or* (3) to contract with a vendor to establish MAIC prices. The DHCS states that changes in the MAIC calculation are necessary because the existing Medi-Cal MAIC depends on the use of AMP as reported by the federal CMS to states. However, due to a federal court injunction and federal law changes, the federal CMS cannot readily provide this information to states.

The DHCS contends that the benefits to this trailer bill change are as follows:

- Increases the use of generic drugs in the Medi-Cal Program.
- Establishes a maximum reimbursement process that has been inactive in the Medi-Cal Program.
- Will maintain or increase savings in Medi-Cal.

Establishment of the new MAIC will reduce payment for many generic drugs. This will affect the reimbursement amount received by some pharmacies since the DHCS is not proposing any adjustments to the dispensing fee component of the rate. However, this proposal will also increase the use of some generic drugs. The DHCS contends that a shift away from some brand name drugs to generics with the new MAIC can be expected to financially benefit some pharmacies.

Overall, the extent of savings will depend on the differences between the current reimbursement and the new MAIC, and in those situations where the brand name drug is preferred, the difference between the net cost (cost after rebates) of the brand name drug and the net cost of the generic drugs, plus the drug utilization patterns after the new MAIC is established.

Prior Subcommittee Hearing—Concerns with Trailer Bill Language. In the April 23rd Subcommittee hearing, constituency groups expressed a few concerns regarding the crafting of the trailer bill language.

Key concerns expressed in the prior Subcommittee hearing included the following:

- The proposed trailer bill language needs to be more explicit in determining how the new MAIC will be set.
- The new MAIC for Medi-Cal should only be determined for those generic drugs that do not have a Federal Upper Limit established by the federal CMS.
- The new MAIC should only be determined for products that have at least three "A-rated" sources of every strength and are widely available for purchase in California pharmacies.

The Subcommittee discussed the language and requested the DHCS to work with stakeholders to re-craft it.

Administration's Revised Trailer Bill Language (Hand Out). In response to concerns raised by interest groups, the Administration modified their trailer bill language to address *four* specific concerns. *First,* the DHCS agreed to establish a MAIC only when *three* or more generically equivalent drugs are available for purchase and dispensing by retail pharmacies in California. Previously the DHCS had proposed when only two or more were equivalent drugs. This change means that it is more likely for a pharmacy to obtain a competitive drug ingredient cost in the first place (i.e., when there is three or more).

Second, the DHCS clarified certain vendor provisions so the language is more clearly constructed as to how the MAIC will be set.

Third, the DHCS added a provision to enable providers to seek a change to a specific MAIC when the provider believes the MAIC does not reflect current available MAIC prices. If the DHCS determines the MAIC change is warranted, the DHCS may update a specific MAIC.

Fourth, the DHCS is proposing to use a volume weighted average based on specific drugs dispensed to Medi-Cal enrollees to help ensure that the MAIC is fully applicable to California and the Medi-Cal marketplace.

Background—Summary of Previous Efforts Regarding MAIC. MAIC is an upper payment limit that creates a maximum reimbursement for generically equivalent drugs. MAIC is only used by Medi-Cal.

Originally, MAIC was defined in regulations as being equal to Average Wholesale Price (AWP) minus 5 percent price of a reference generic drug (typically the drug with the lowest AWP) with the provision that the Drug Manufacturer of the generic drug would be able to provide enough drug products to meet Medi-Cal's needs.

Unfortunately, this regulation did not mandate for Drug Manufacturers to supply this information. Therefore, the DHCS was generally unable to establish new MAIC prices. As a result a "new" MAIC definition was established in state statute in 2004.

This MAIC definition in 2004 was to be based on the Wholesale Selling Price (WSP). WSP was to be the weighted (by unit volume) mean price, including discounts and rebates, paid by a pharmacy to a wholesale drug distributor. Instead of using a single product, this methodology would use all generic equivalent products to calculate a weighted average that would be MAIC.

This 2004 definition of MAIC was halted when Congress declared they would move to an Average Manufacturer's Price (AMP) based on Federal Upper Limits (FUL). In 2007 this definition was changed to make MAIC equal to the mean of the AMP of drugs generically equivalent to the particular innovator (i.e., brand drug) plus a percent markup determined by the DHCS to be necessary for MAIC to represent the average purchase price paid by retail pharmacies in California.

The federal CMS issued regulations (to be effective October 1, 2007) regarding this calculation of FUL and AMP prices. However, the National Association of Chain Drug Stores and the National Community Pharmacists Association filed a complaint for injunctive relief contending that implementation was unlawful and would cause harm. Federal court issued a temporary injunction barring federal CMS implementation. Further, House Resolution 6331 delays implementation of FUL prices and AMP reporting until October 1, 2009.

Since the MAIC for Medi-Cal relies on the use of AMP reported by the federal CMS to states, it has been impacted by both the federal court injunction as well as the delay enacted in H.R. 6331.

Background—Pharmacy Reimbursement Under Medi-Cal. Pharmacy reimbursement consists of two components—a drug ingredient cost and a dispensing fee. With respect to the drug ingredient cost component, Medi-Cal presently calculates this cost at the "Average Wholesale Price" minus 17 percent. The dispensing fee component is $7.25 per prescription except for long-term care pharmacies which receive $8.00 per prescription.

Generally, the drug ingredient cost constitutes about 85 percent of the payment per prescription to a Pharmacy.

The rate reduction for Pharmacy reimbursement enacted in AB 1183, Statutes of 2008, is presently not in affect due to a court injunction (a 10 percent reduction effective July 1, 2008 to February 2009 and then a 5 percent reduction effective March 1, 2009).

Background—Description of Key Terminology. The following key definitions and terminology are provided only as a reference for discussion purposes.

- Average Manufacturer Price (AMP). This is the average price paid to the Drug Manufacturer for the drug in the United States by wholesalers for drugs distributed to retail pharmacies.
- Average Wholesale Price (AWP). Historically, the AWP has been the generally accepted drug payment benchmark for many payers because it was readily available. The primary sources of AWP are the drug data companies—most notably "First Data

Bank". The Medi-Cal Program currently uses First Data Bank as the source of AWP and other drug data reported by the Drug Manufacturers. Drug companies updated their database files continuously. Many pharmacies and third party payers, including Medi-Cal, obtain updated pricing on a weekly basis.

- Wholesaler Acquisition Cost (WAC). The WAC is generally a list price set by Drug Manufacturers for each of their products. WAC is supposed to represent what a wholesaler pays for a drug. However, WAC does not reflect discounts or price concessions offered by Drug Manufacturers. Drug Manufacturers report WAC prices directly to First Data Bank.

- Federal Upper Limit. Prior to certain federal law changes, the Federal Upper Limit (FUL) was defined as the reimbursement limit for each multiple source drug for which the federal Food and Drug Administration has *rated three or more* products therapeutically equivalent. Generally, drug products are considered pharmaceutical equivalents if they contain the same active ingredients are of the same dosage form, route of administration and are identical in strength or concentration.

  Federal law changes (Deficit Reduction Act of 2005) decreased the number of equivalent drugs from three to two and changed the reimbursement calculation. As noted above, these federal changes have not been implemented.

- Non-Innovator Multiple Source Drug. These drugs are often referred to as "generic drugs" and are *therapeutically equivalent* to Innovator Multiple Source Drugs which are referred to as "brand drugs".

Subcommittee Staff Comment and Recommendation--Approve. The DHCS has responded to many of the constituency group concerns and it is recommended to adopt the DHCS language at this time as placeholder.

Questions. The Subcommittee has requested the DHCS to respond to the following question:

1. **DHCS,** Please provide a *brief* description of the revised trailer bill language.

3. Trailer Bill Language & Staff for Mental Health Services Supplemental Payments Program (Hand Out)

Budget Discussion Issue. The Subcommittee is in receipt of a Spring Finance Letter to develop and implement a Mental Health Services Supplemental Payment Program to be administered by the Department of Health Care Services (DHCS).

This new Mental Health Services Supplemental Payment Program would be modeled after other existing DHCS "supplemental payment" programs. Specifically, it would authorize County Mental Health Plans (County MHPs) to submit "certified public expenditures" (CPEs) to the DHCS for the purpose of claiming federal financial participation to reimburse County MHPs for the costs of mental health services provided to Medi-Cal enrollees that *exceed their current payment levels*.

The supplemental payment would consist of the difference between the current Fee-For-Service rate being paid for these services and the actual costs to the counties to provide the mental health services. It should be noted that these supplemental payments can also be used to reimburse providers of Medi-Cal mental health services other than counties; however, it is the county CPE that must be used to claim the federal reimbursement.

Participation in the program by counties would be *completely voluntary*. The DHCS would invite counties to participate on an annual basis. Generally, it would be large counties who would most likely choose to participate in order to claim the additional federal funds since they are more likely to be incurring these costs.

It should be noted that the DHCS has already submitted a *draft* State Plan Amendment to the federal CMS in order to implement the program retroactively to January 1, 2009. This provides California with a longer period in which to claim federal reimbursement for these uncompensated county expenditures. This new program would be eligible to obtain the federal ARRA level of federal FMAP at 61.59 percent.

Based on preliminary information as contained in the draft State Plan Amendment, it is anticipated that $27.7 million (federal funds) can be obtained for 2008-09 and $55.4 million can be obtained for 2009-10. This increased federal funding would be very beneficial to local entities providing mental health services.

Prior Subcommittee Hearing. The Subcommittee discussed this issue in its April 23rd hearing. In this hearing several constituency groups expressed concerns regarding the DHCS trailer bill language. As such, the Subcommittee requested the DHCS to work with constituency groups and legislative staff to re-craft the proposed language.

Administration's Revised Trailer Bill Language (Hand Out). The DHCS has re-crafted its trailer bill language to incorporate several of the constituency groups concerns. *Key* changes include the following:

- Clarified that "certified public expenditure" (CPE) are funds expended by "public agencies", including counties, cities, city and county, or the University of California. This clarification will recognize the availability of more CPE to match with federal funds.

- Clarified Subdivision (c)(2) of Section 5783 to make it clear that County Mental Health Plans, or other public agencies, will reimburse contractors based on actual, allowable costs as determined by California's Medi-Cal State Plan, and shall be made on an interim basis until such time as actual, allowable costs are finally determined.

  In addition, (c)(3) of this section was changed to provide public agencies with one or more lump sums of federal supplemental payment or on any other federally permissible basis. This way public agencies can receive federal supplemental payments in a timely manner and not have to "float" their funds for periods of time waiting for federal reimbursement.

- Provides for the DHCS to adopt regulations as necessary to implement this new supplemental payment method but that Medi-Cal bulletins or similar instruction will be used for expedited implementation purposes until June 30, 2011.

Subcommittee Staff Comment and Recommendation. The DHCS has modified the trailer bill language to incorporate several changes. The DHCS notes that the opportunity for public agencies (primarily County Mental Health Plans) to obtain supplemental mental health funding through the use of CPEs is *voluntary* and requires federal Centers for Medicare and Medicaid (CMS) approval. As such, the DHCS needed to craft their revisions in a manner that would be acceptable to public agencies and the federal CMS.

It is recommended to adopt the revised trailer bill language as placeholder.

Questions. The Subcommittee has requested the DHCS and DMH to respond to the following questions:

1. **DHCS**, Please provide a *brief* summary of the revised trailer bill language.
2. **DHCS and DMH**, How will coordination occur across the two departments to ensure appropriate development and implementation of this program?

4. Genetic Handicapped Persons Program—Three Proposals from the DHCS (See Hand Out)

Budget Issues Discussion. The February budget package provides a total of $78.1 million ($44.5 million General Fund) for 2009-10 which reflects a *net* increase of $5.8 million (total funds) as compared to the revised current-year.

The Table below reflects the DHCS' assumes for base expenditures for certain specified diseases.

Table: DHCS Base Expenditure Assumptions for Specified Disease for 2009-10

Diagnosis	Average GHPP-Only Caseload	Average Annual Cost per Case	Total Program Expenditure
Hemophilia	428	$165,100	$70,646,000
Cystic Fibrosis	412	14,500	5,963,000
Sickle Cell	310	3,600	1,108,000
Huntington's	160	2,100	342,000
Metabolic	116	700	82,000
Total People	1,426	$54,800	$78,141,000

This appropriation assumes passage of trailer bill language to change the structure of the Genetically Handicapped Persons Program (GHPP). The trailer bill language was *not* adopted as part of the February budget package.

After working with constituency groups and legislative staff, the DHCS has revised its original language to craft a more workable product. Specifically, the *revised* trailer bill language contains *three key components* as described below.

- 1. New "Crowd-Out" Provisions. The trailer bill would add *new* provisions to the GHPP to encourage continued enrollment in employer-sponsored health insurance, where applicable, and to make some individuals *ineligible* for the GHPP for a period of up to six months if they are terminated from their existing employer-sponsored health insurance *unless* certain conditions occur. These conditions include: (1) a loss of employment or a change in employment status; (2) a change in address to a zip code that is not covered by the employer-sponsored coverage; (3) the employer discontinued health benefits to all employees; (4) the death of an individual, or legal separation or divorce from the individual through whom the applicant was covered; (5) the applicant's employer-sponsored health coverage became unavailable because the services paid for under such coverage attained the lifetime coverage limit; or (6) coverage was under a COBRA policy, and the COBRA coverage period has ended. An individual may appeal decisions of ineligibility and the DHCS must provide written notification of any ineligibility determination.

  The language also provides the Director of the DHCS with the authority to waive determinations of *ineligibility* pursuant to this new provision if it will result in undue hardship. Further, the language provides for a stakeholder process for implementation purposes.

The DHCS states that this change is needed in order to prevent individuals from dropping their employer-sponsored health care coverage to enroll into the GHPP. If an individual is eligible for Medi-Cal then this "crowd-out" provision does *not* apply. The DHCS estimates savings of $14,000, assuming a July 1, 2009 implementation date.

- 2. DHCS Authority to Pay Premiums for Other Health Care Coverage. The trailer bill would add new provisions to provide the DHCS with authority to pay premiums for a GHPP client's other health care coverage that will pay for the GHPP client's health care services in lieu of the GHPP. The DHCS does have this authority in certain other programs where it is cost-beneficial for the state. The DHCS estimates savings of $593,000 (General Fund) from this action, assuming a July 1, 2009 implementation date.

- 3. GHPP Enrollment Fee. The trailer bill would re-craft the existing GHPP Enrollment Fee and increase the level of the fee to be 1.5 percent of total gross income for families with incomes from 200 percent to 300 percent of poverty, and up to 3 percent for families with incomes greater than 300 percent of poverty. This is would be an annual fee.

  In the event the annual enrollment fee determined exceeds the cost of care incurred during the applicable year of enrollment, the DHCS shall reduce the enrollment fee by refund or credit it to an amount equal to the cost of care. The DHCS estimates savings of $1.4 million (General Fund) from this action, assuming a July 1, 2009 implementation date.

Follow-Up Regarding Collection of Drug Rebates for Blood Factor Product. As noted in the Table above, 90 percent of the expenditures for the GHPP are for the treatment of Hemophilia. A significant expenditure for the treatment of Hemophilia is the provision of Blood Factor Product.

As directed by trailer bill legislation in 2003, the DHCS is to collect rebates from manufacturers of Blood Factor Product. In 2008, the DHCS experienced problems with the collection of these GHPP rebates. Specifically, the DHCS Director noted that $4.4 million in rebate funds were due the State dating back to June 2006 (March 2008 letter). It was anticipated that these "past due" rebates would be collected, and ongoing rebates would be obtained.

Presently, the GHPP budget reflects the following drug rebate collections:

Fiscal Year 2008-09 Collection		Fiscal Year 2009-10 Collection	
2006-07 =	$500,000	2008-09 =	$2,000,000
2007-08 =	$3,900,000	2009-10 =	$2,000,000
2008-09 =	$2,000,000		
TOTAL =	**$6,400,000**	**TOTAL =**	**$4,000,000**

It would be useful to hear from the DHCS with respect to the status of drug rebate collections to ensure that the State is indeed obtaining the level of drug rebate it should be for this critical program, particularly given these difficult fiscal circumstances and changes in the structure of the GHPP as proposed in trailer bill by the DHCS.

Background—Genetically Handicapped Persons Program (GHPP). The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially *ineligible* for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fees and treatment costs based on a sliding fee scale for family size and income.

Subcommittee Staff Comment and Recommendation. The DHCS has modified their trailer bill language in response to concerns expressed by constituency groups. It is recommended to adopt this revised trailer bill language as placeholder language.

Further, the DHCS should provide an update regarding its collection of drug rebates within the GHPP.

Questions. The Subcommittee has requested the DHCS and DMH to respond to the following questions:

1. **DHCS**, Please provide a brief summary of the program, and the proposed trailer bill changes.
2. **DHCS**, Please provide an update regarding the collection of drug rebates under the GHPP. Are all drug manufacturers providing the State with rebates as required? Is it likely that more rebates will be collected in 2009-10 since drug expenditures are likely to increase?

5. California Children's Services (CCS) Program (See Hand Out for Letters)

Summary of Budget Appropriation. The CCS program is a complex program that provides specialized, pediatric health care services to low-income children and young adults, aged 21 years and under, who have CCS-eligible medical conditions.

The February budget package for the CCS Program, within the DHCS' Children's Medical Services Division, is $270.4 million (total funds). This budget includes expenditures for county administration, CCS-Only children, CCS-Healthy Families Program children, certain therapy costs, and other administrative support activities (such as fiscal intermediary processing and information technology). (Most expenditures for CCS-Medi-Cal children are in the Medi-Cal Program budget).

The 2009-10 State appropriation of $270.4 million ($69.3 million State Funds, $134.9 million federal Healthy Families Program funds, $59.3 million federal funds from the Safety Net Care Pool, $6.9 million federal Title V Maternal and Child Health Funds) reflects an increase of $22.1 million (total funds) as compared to the revised current-year.

As a "county-realignment" program, the DHCS estimates that counties will provide about $117.8 million in County Funds for their share of the CCS Program.

Constituency Concerns—County Administration of CCS Eligibility and Case Management Funding. The Subcommittee is in receipt of letters expressing concerns regarding both the adequacy and allocation of funding to counties to perform CCS county administrative functions.

Specifically, the DHCS implemented a new method of funding CCS county administrative functions in 2008, including CCS eligibility determinations, and case management functions which includes the authorization of services to providers for medically-needy children requiring CCS services.

As a result of this new DHCS methodology, some counties and provider groups contend that CCS eligibility determinations will be delayed and children will not be referred for services to physicians and hospitals in a timely manner.

Overall Background on CCS: The DHCS administers the CCS Program. Their *primary* functions are (1) establishing policy and procedures for the program; (2) certifying CCS participating pediatric specialty care providers, and (3) reimbursing providers for services. In addition, the State operates three Regional Offices to provide assistance, as noted below, for smaller counties.

Other CCS Program administrative functions, including making eligibility determinations, providing authorization for case management, and providing authorization for medical treatment of services are conducted *primarily* at the county level. Large counties operate their own CCS Programs whereas smaller counties share the operation of their program administration with State CCS Regional Offices in Sacramento, San Francisco, and Los Angeles.

The CCS Program is the oldest managed health care program in the State and the only one focused specifically on children and young adults (up to age 21) with special health care needs.

CCS provides medical diagnosis, case management, medical treatment and therapy to financially eligible children with specific medical conditions, including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence. Only *certain conditions* are eligible for CCS coverage. Further, CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program), **(2)** CCS and Medi-Cal eligible, and **(3)** CCS and Healthy Families eligible. All children must be a permanent resident of the California County where they apply for CCS enrollment.

For CCS-only children to be considered financially eligible, they must either (1) be uninsured with an annual family income of less than $40,000; or (2) projected to have more than 20 percent of annual family income for treatment of a CCS condition.

The CCS Program depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., *carved-out service*).

Funding for the program is a patchwork consisting of State General Fund support, County Realignment Funds, and federal reimbursement provided under the federal Children's Health Insurance Program (i.e., Healthy Families in California) and the Medi-Cal Program as applicable.

Subcommittee Staff Comment and Recommendation. The CCS Program is complex and comprehensive discussions need to occur regarding the program. Subcommittee staff contends that CCS eligibility and treatment authorization can be, and should be, streamlined in an effort to reduce administrative burdens and to better serve the child and family.

The DHCS needs to consider a more comprehensive approach to address both short-term and longer-term CCS Program needs. For the short-term, the following Budget Bill Language is proposed to address immediate concerns:

"The department shall convene a diverse workgroup as applicable that, at a minimum, represents families enrolled in the CCS Program, counties, specialty care providers, children's hospitals, and medical suppliers to discuss the administrative structure of the CCS Program, including eligibility determination processes, the use and content of needs assessment tools in case management, and the processes used for treatment authorizations. The purpose of this workgroup will be to identify methods for streamlining, administrative cost-efficiencies, and better utilization of both State and county staff, as applicable, in meeting the needs of children and families accessing the CCS Program. The department *may* provide the policy and fiscal committees of the Legislature with periodic updates of outcomes as appropriate.**"**

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. DHCS, Please provide a brief overview of the CCS Program and discusses that have occurred over this past year regarding changes to CCS county administrative allocations. What next steps are anticipated in the short-term and longer-term?